



Send completed form by fax or email to the following:

CMS Provider Management

Fax: (850) 487-1279

Email: cmsproviderhelp@doh.state.fl.us

## Medical Director Recommendation for RPICC Provider Approval

Medical Director Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

The physician listed below has applied to CMS for participation in the following:

Physician Name \_\_\_\_\_

City/County \_\_\_\_\_

Specialty/Sub-specialty \_\_\_\_\_

Hospital Affiliation \_\_\_\_\_

CMS Program Regional Perinatal Intensive Care Center (RPICC)

Upon consideration of the above named physician, I have made the following recommendation for CMS participation:

- ☐ I have professional knowledge of the above named physician and **recommend** him/her for approval for participation as a CMS RPICC provider.
- ☐ I have professional knowledge of the above named physician and **do not recommend** him/her for approval for participation as a CMS RPICC provider.
- ☐ I have no knowledge of the above named physician.

Comments (attach additional pages if necessary):

\_\_\_\_\_  
Signature of Medical Director

\_\_\_\_\_  
Print Name of Medical Director

\_\_\_\_\_  
Date